MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87-C

CERTIFICATE OF DEATH

10514

Reg. Dist. No. 96

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 3 days

Hospital, institution, or street address where death occurred:
Veterans' Administration

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 107 Eye Street, N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War

3. (a) FULL NAME: BRADLEY, John F.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widower

6.(b) Name of husband or wife: Unknown

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 15, 1892

8. AGE: Years	Months	Days	If less than one day
48	5	27	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Railroad employee

11. Industry or business:

FATHER
12. Name: Joseph Aloysius Bradley - deceased
13. Birthplace: Unknown

MOTHER
14. Maiden name: Johanna Brill Bradley - deceased
15. Birthplace: Unknown

16. Informant: Hospital records
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 12, 1940 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Ft. Myer, Virginia

18. Funeral director: per J.F. McC. W.W. Chambers Co
W.W. CHAMBERS COMPANY

Address: 1400 Chapin St., N.W., Washington, D.C.

19. Oct. 12, 1940. Irma E. Daugherty.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11, 1940, at 8:35 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 9, 1940, to Oct. 11, 1940 and that I last saw him alive on October 11, 1940

	DURATION
Immediate cause of death: Chorea, Huntington's	Unknown
Due to:	
Due to:	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: --- Date of op.:

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of:

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: -- Injured at work? --

23. SIGNATURE: C. F. Davis
C. F. DAVIS, M.D., Clinical Director
Address: Veterans' Administration Perry Point, Maryland. Date signed: 10-12-40

RECEIVED
OCT 18 1940
BUREAU V. S.

10515

STATE OF MARYLAND
CERTIFICATE OF DEATH

(131-B)

Registration Dist. No. 90

[1]PLACE OF DEATH

County Cecil

Village or City Warwick (No. _____ St.: _____ Ward) (if death occurred in a hospital or institution, give its NAME instead of street and number.)

[2]FULL NAME Elizabeth Briscoe

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): married.

6 DATE OF BIRTH: Oct (Month) 21st (Day) 1887 (Year)

7 AGE: 53 yrs. 0 mos. 10 ds. If LESS than 1 day ___ hrs. or ___ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work: House-wife
(b) General nature of industry business, or establishment in which employed or (employer): _____

9 BIRTHPLACE (State or country): Maryland -

PARENTS

10 NAME OF FATHER: John Brown

11 BIRTHPLACE OF FATHER (State or country): Don't Know.

12 MAIDEN NAME OF MOTHER: Ida Queen

13 BIRTHPLACE OF MOTHER (State or country): Don't Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Viola Bundy

(Address) Warwick - Md.

15 Filed Nov. 12, 1940 Irving Bisbee Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 31st (Day) 1940 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 5/19 1940 to Oct 31st, 1940, that I last saw her alive on Oct 24, 1940, and that death occurred on the date stated above, at 5:30 A.m.

The CAUSE OF DEATH * was as follows:

Chronic Nephritis
Mitral Stenosis + Mitral Regurgitation

(Duration) 1 yrs. + mos. ___ ds.

Contributory Secondary _____

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Dorsey W. Lewis M. D.

Nov 1st 1940 (Address) Middletown - Del.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 53 yrs. ___ mos. ___ ds. In the State 53 yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL: Bohemia cemetery Warwick Md.

DATE OF BURIAL: 11/4/, 1940

20 UNDERTAKER: G. Lister Daniels

ADDRESS: Townsend Del.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 5 1910

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117C)

10516

CERTIFICATE OF DEATH

Reg. Diat. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS AT

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:
Veterans' Administration

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegheny

City or town: Flint Stone
(If outside city or town limits, write RURAL and give nearest town)

Street No. ____
(If rural, give LOCATION)

2.(a) If veteran, name war: World War

3. (a) FULL NAME

BUCY, Clifton G.

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Unknown - approx. 53 yrs.

8. AGE: Years	Months	Days	If less than one day
53	unknown		____ hrs. ____ min.

9. Birthplace: Flint Stone, Md.
(Town, county, and state)

10. Usual occupation: Farmer - laborer

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital records
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 14, 1940. (month) (day) (year)

Cemetery or crematory: Unknown

Location: Cumberland, Md.

19. Funeral director: Pennington & Son
PENNINGTON & SON

Address: Havre de Grace, Md.

19. 10-14-1940. (Date rec'd by registrar) June E. Daughety Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14 19 40 at 5:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 24 19 40, to October 14 19 40 and that I last saw him alive on October 14 19 40

Immediate cause of death	DURATION
Perforating duodenal ulcer, with	More
Abscess in lesser peritoneal cavity	than
Due to:	2 months
Due to:	
Other conditions:	
Pneumonia, lobar	3 days

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op. --

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of ____

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work?

23. SIGNATURE: C. F. Davis
C. F. DAVIS, M.D., Clinical Director

Address: Veterans' Administration, Perry Point, Md. Date signed 10-14-40

CEIVED
NOV 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

10517

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:

County: Cecil

City or town: North East
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: North East
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Margaret Jane Burns

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Jonathan C Burns

6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): Dec 3 1855

8. AGE: Years: 84 Months: 10 Days: 28 If less than one day: hrs. min.

9. Birthplace: Cecil Co Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Thomas Terry
13. Birthplace: Cecil Co. Md

MOTHER
14. Maiden name: Margaret Cohen
15. Birthplace: Ireland

16. Informant: Mrs Murray Cameron
Address: North East Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 2 1940 (month) (day) (year)

Cemetery or crematory: Bay View Methodist

Location: Bay View Cecil Co Md

18. Funeral director: Joseph R Grant
Address: North East Md

19. Nov 2nd 1940 (Date rec'd by registrar) Lida V. Owens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 31 1940, at 7.05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1934 19 , to Oct 31, 1940 and that I last saw her alive on Oct 30, 1940

Immediate cause of death: Gen Marasmus

Due to: Arteriosclerosis

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

	DURATION
Gen Marasmus	14 days
Arteriosclerosis	2 years

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. G. Cantwell M. D. or other

Address: North East Md Date signed: Nov 1 1940

RECEIVED
DEC 3 1960
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

10518

Reg. Diat. No. 90

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil Co.
City or town: Ceciltown, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Ceciltone
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James H. Burris

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Sarah J. Burris
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 28th 1854

8. AGE:

Years	Months	Days	If less than one day
85	10	16	..... hrs. ..... min.

9. Birthplace: Near Clayton Delaware
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business
FATHER 12. Name: Henry Burris
13. Birthplace: Dickenson
MOTHER 14. Maiden name: Sarah Elisha
15. Birthplace: Unknown
16. Informant: Grace B. Fillingame
Address: Cecilton, Md.
17. Burrials (Burial, cremation, or removal. Which?) Date thereof 10/16/40 (month) (day) (year)
Cemetery or crematory: Galena Cemetery
Location: Galena Md
18. Funeral director: John H. Talbage
Address: Cecilton, Md.
19. Oct. 16 1940 (Date rec'd by registrar) Thos. J. Burba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14 1940 at 2.05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1938, to Oct 14 1940
and that I last saw him alive on Oct 14 1940

Immediate cause of death	DURATION
Acute Chronic Myocarditis	
Due to: Chronic Hypertrophic arthritis	Several years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Henry V. Davis M.D.
M. D. or other
Address: Chesapeake City Md Date signed: 9/17/40

CEIVED
NOV 5 1940

Dr Johnson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

10519

CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Union Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 72 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: X

3. (a) FULL NAME: Richard Byard

3. (b) Social Security Number: X

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife: Mary Byard
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 9 1867

8. AGE:

Years	Months	Days	If less than one day
72	11	4	hrs. min.

9. Birthplace: Elkton Cecil Md
(Town, county, and state)

10. Usual occupation: Laborer, (Day)

11. Industry or business:

FATHER
12. Name: Lewis Byard
13. Birthplace: Elkton Md

MOTHER
14. Maiden name: Martha Alexander
15. Birthplace: Elkton Md

16. Informant: Carrie Jones
Address: Wilmington Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 16 1940 (month) (day) (year)
Cemetery or crematory: Elkton (Colored)
Location: Elkton. Md

18. Funeral director: H. W. Pippin
Address: Elkton Md

19. Oct 16 1940 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 13 1940, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 21 1940, to Oct 13 1940, and that I last saw him alive on Oct 12 1940.

Immediate cause of death	DURATION
Uremia	3 days
Due to Chr Parenchymatous nephritis	4 yrs.
Chr. Retention of Urine	3 months
Due to	
Other conditions: Chr-Constipation	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James L. Johnson M.D.
M. D. or other
Address: Elkton, Md Date signed 10/15/40

RECEIVED
NOV 5 1940
U. S.

10520

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 95

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Rowlandville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 62

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Rowlandville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rosanna Caldwell Davis

3.(b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Wm. Edward Davis

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 9 - 1878

8. AGE: Years: 62 Months: 4 Days: 9 If less than one day ... hrs. ... min.

9. Birthplace: Rowlandville Cecil Co Md (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER
12. Name: C C Caldwell
13. Birthplace: Rowlandville

MOTHER
14. Maiden name: Virginia Ross
15. Birthplace: Darlington

16. Informant: Mrs Saml H. Moore

Address: Colora Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 21 1940 (month) (day) (year)

Cemetery or crematory: Harmony Chapel Cemetery

Location: Near Rowlandville

18. Funeral director: J. E. Tyson

Address: Rising Sun. Md.

19. 10/20 1940 (Date rec'd by registrar) L M Worthington Registrar

Permit issued 10-20-1940

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1940, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1940, to Oct 18 - 1940 and that I last saw her alive on Oct 18 1940

Immediate cause of death: Chronic Myocarditis, Chronic Endocarditis — DURATION: 1935

Due to

Due to: Chronic Nephritis. — 1935

Other conditions (include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: C J Benson M. D. or other

Address: Port Deposit Md Date signed: 10-19-40

RECEIVED
NOV 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

10521

131-a

1. PLACE OF DEATH

County Cecil Registration Dist. No. 2 - 90

Village or City Ceciltou - Md. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred Lifer yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME William Thomas Hall If U. S. Veteran, specify WAR

(a) Residence: No. Ceciltou St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Colored	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Stella (Moore) Hall

6. DATE OF BIRTH (month, day, and year) March 15 - 1872

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	6	29	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Barber -

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Ceciltou (State or country) Md.

FATHER

13. NAME Wm Thomas Hall

14. BIRTHPLACE (city or town) Cecil Co. (State or country) Md.

MOTHER

15. MAIDEN NAME Mary Lawson

16. BIRTHPLACE (city or town) Cecil Co. Md (State or country)

17. INFORMANT Mrs Stella Hall. (Address) Ceciltou - Md.

18. BURIAL, CREMATION, OR REMOVAL Place Ceciltou Date Oct 17, 1940

19. UNDERTAKER H. W. Lippin (Address) Elkton Md.

20. FILED Oct. 17th, 1940 Irving Burke Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Oct. 14 - (Month) (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Sept 13, 1936, to Oct 14, 1940

I last saw him alive on Oct 13, 1940; death is said to have occurred on the date stated above, at 6 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Acute Cardiac Dilatation	
Other Contributory Causes of Importance: Cerebral Hemorrhage.	Sept 13 - 1936
Cardio Renal Disease.	

Name of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy? —

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury —, 19

Where did injury occur? — (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? no -

If so, specify —

(Signed) Catherine Goodson M. D.

(Address) Ceciltou - Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED NOV 5 1927

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

M

S

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (S)

10522

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Union Hospital
Stay in hospital or inst. (yrs., or mos., or days): 1 hr
Stay in this community (yrs., or mos., or days): 1 hr

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 131 Moffet St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Baby Hutchison unnamed

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife:
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct 8 1940

8. AGE: Years | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace: Elkton Cecil Maryland
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: George T. Hutchison
13. Birthplace: Delaware City Delaware

MOTHER
14. Maiden name: Lula McKelvy
15. Birthplace: Baltimore Maryland

16. Informant: George T. Hutchison
Address: 131 Moffet St Elkton Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Oct 9 1940 (month) (day) (year)
Cemetery or crematory: Bethel
Location: Chesapeake City, R.D. Bethel Md

18. Funeral director: H. W. Pippin
Address: Elkton

19. Oct 9 1940
(Date rec'd by registrar)
F R Frazer
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1940 10 45 a.m. 10 45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7 1940, to October 7 1940, and that I last saw h____ alive on ____ 19____.

Immediate cause of death: Monstrosity — Malformation of cerebral malformation — (absent vault of skull)
Due to
Due to
Other conditions: —
(Include pregnancy within 3 months of death)
Major findings:
Of operations: —
Of autopsy: —

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Milford H. Sprecher, M.D.
M. D. or other
Address: Elkton, Md Date signed: Oct 9, 1940

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (46 [illegible])

10523

CERTIFICATE OF DEATH

Reg. Dist. No. [illegible]

CECIL

1. PLACE OF DEATH:
County Ninth district Maryland
City or town
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Rebecca A. Janney.

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife XXXXXXXX
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9 1878

8. AGE: Years	Months	Days	If less than one day
62	8	6	hrs. min.

9. Birthplace Cecil Co Md.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name Jesse Janney
13. Birthplace Maryland

MOTHER
14. Maiden name Sarah Kimble
15. Birthplace Pennsylvania

16. Informant Mrs Sarah C Deaver
Address Calvert Md

17. Burial 1940 Date thereof Oct 18 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Bay View Md.
Location Bay View Maryland.

18. Funeral director J. E. Hopson
Address Rising Sun Md.

19 Oct. 16 1940 [illegible] Worthington
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1940 to October 15 1940, and that I last saw her alive on October 14 1940.

Immediate cause of death Carcinoma of the Sigmoid Colon — DURATION 6 months
Due to —
Due to —
Other conditions —
(Include pregnancy within 3 months of death)
Major findings: —
Of operations
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F. B. Robinson, M.D.
M. D. or other
Address Oxford, Penna. Date signed

Permit issued 10/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (91b)

10524

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:
County: Cecil
City or town: Royal near Port Deposit
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Royal near Port Deposit Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Between Woodlawn & West Nottingham
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Frank B. Kelly

3. (b) Social Security Number: none

4. Sex: male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): May 12, 1871

8. AGE: Years: 69 Months: 5 Days: 4 If less than one day ____ hrs. ____ min.

9. Birthplace: Port Deposit, Maryland
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farm

FATHER
12. Name: Samuel Kelly
13. Birthplace: Woodlawn, Md.

MOTHER
14. Maiden name: Ellen Lukens
15. Birthplace: Chester Co. Pa

16. Informant: Clarence Kelly
Address: Port Deposit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-18-1940 (month) (day) (year)
Cemetery or crematory: Rosebank
Location: Calvert, Md.

18. Funeral director: Ralph M Reed
Address: Rising Sun, Md.

19. Oct 18 1940 (Date rec'd by registrar) L M Worthington Registrar

Permit issued 10-18-1940

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15 1940, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 1940, to Oct. 15 1940, and that I last saw him alive on Oct. 15 1940.

Immediate cause of death: Endocarditis Acute — DURATION: 2 wks
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: W G Jaen M. D. or other
Address: Port Deposit Md Date signed Oct. 15 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. S.

10525

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County Cecil
City or town Elkton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Union Hospital
Stay in hospital or inst. (yrs., or mos., or days) 1 day
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Conowingo Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Elkton RD 3
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Leeds

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) No information

8. AGE: Years about 80 3/4 | Months 4 | Days | If less than one day hrs. min.

9. Birthplace (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name No information
13. Birthplace " "

MOTHER 14. Maiden name " "
15. Birthplace " "

16. Informant Mrs Edna Folland
Address Elkton RD Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 6 - 1940 (month) (day) (year)

Cemetery or crematory Churchhill Cemetery

Location Churchhill Cecil Co Md

18. Funeral director Florence E Abramathy
Address Elkton RD 6 Md

19. Oct 5 1940 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2, 1940, at 12:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1940 to Oct 2 1940, and that I last saw him alive on Oct 2 1940

Immediate cause of death	DURATION
Cerebral Apoplexy	Oct 1
Due to General arterio Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Herbert Bates M. D. or other
Address Elkton Md Date signed 10/2/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
TREASURY DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (157-2)

10526

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Union Hospital.
Stay in hospital or inst. (yrs., or mos., or days): 1 day.
Stay in this community (yrs., or mos., or days): 1 day.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Northeast Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Cecil Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Baby Boy Lewis
3. (b) Social Security Number:

4. Sex: Mals. (?)
5. Color or race: White
6. (a) Single, married, widowed, or divorced:
6 (b) Name of husband or wife: —
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Oct. 12. 1940.

8. AGE: Years | Months | Days: 1 | If less than one day ____ hrs. ____ min.

9. Birthplace: Northeast, Cecil, Maryland
(Town, county, and state)
10. Usual occupation: —
11. Industry or business: —

FATHER
12. Name: W. Rodney Lewis
13. Birthplace: Elk Mills, Md.

MOTHER
14. Maiden name: Beatrice Reynolds.
15. Birthplace: Northeast, Md.

16. Informant: Mrs. Beatrice Lewis.
Address: Northeast, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 14 1940 (month) (day) (year)
Cemetery or crematory: North East Cemetery
Location: North East Md

18. Funeral director: Florence E. Abernathy
Address: Elkton Md R.H. 5

19. Oct 14 1940 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 13 1940, at 7 40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 12 1940, to Oct 13 1940 and that I last saw him alive on Oct. 13 1940.

Immediate cause of death: Asphyxia livida —
Due to: Probably Ⅰ cardiac abnormality;
Due to:
Other conditions: Extradigits; hermaphroditism
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Milford H. Sprecher, M.D. M. D. or other
Address: Elkton, Md. Date signed: Oct. 14.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (186-a)

10527

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 202 Blue Ball Rd Elkton Md
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 202 Blue Ball Rd Elkton Md
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Hannah Matilda Lippincott

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: Hayes Lippincott
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Aug 9 - 1861

8. AGE: Years: 79 Months: 2 Days: 16 If less than one day ____ hrs. ____ min.

9. Birthplace: Near Elkton Cecil CO Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER
12. Name: John Lynch
13. Birthplace: Maryland
MOTHER
14. Maiden name: Melissa Green
15. Birthplace: Maryland
16. Informant: Mrs Geo Hammond
Address: 202 Blue Ball Rd Elkton Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct-30-1940 (month) (day) (year)
Cemetery or crematory: Cherry Hill Cemetery
Location: Cherry Hill Md
18. Funeral director: Florence E Abernathy
Address: Elkton Md R.H. 5
19. Oct 28 1940 (Date rec'd by registrar) F.R. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26 1940, at 1:50 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 21 1940, to Oct 26 1940
and that I last saw her alive on Oct 25 1940

Immediate cause of death: Fracture femur, left due to any accidental fall, in her home. CWGR.
Due to: with probable fat embolism
Due to:
Other conditions: Cardio-vascular-renal disease
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

DURATION: Oct 21 / Oct 26

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide, or homicide~~: Accident Date of: Oct 21, 1940
Where did injury occur? Elkton (City or town), Cecil (County), Maryland (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Injured at work?

23. SIGNATURE: Mulford H Sprecher, MD M. D. or other
Address: Elkton, Md Date signed: Oct 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-0)

10528

CERTIFICATE OF DEATH

Reg. Diat. No. 95

1. PLACE OF DEATH:
County: Cecil
City or town: Colora. Rural.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Colora. Rural route
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Sophia Jane Nesbitt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: William Nesbitt
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 9. 1857

8. AGE: Years	Months	Days	If less than one day
83		20	hrs. min.

9. Birthplace: Lancaster Co. Pa.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Marshall Brown
13. Birthplace: Pa.
MOTHER 14. Maiden name: — Walter
15. Birthplace: Pa.
16. Informant: Walter Nesbitt
Address: Colora. Md. R. F. D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 1. 1940 (month) (day) (year)
Cemetery or crematory: West Nottingham Cemetery
Location: near Colora Md.
18. Funeral director: J. E. Tyson
Address: Rising Sun. Md.
19. Oct. 30 1940 (Date rec'd by registrar) L. M. Worthington Registrar

Permit issued 10-30-1940

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29 1940, at 8 20 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 26-1940 to Oct 28 1940
and that I last saw h[illegible] alive on Oct 28 1940.

Immediate cause of death	DURATION
Uremia Nephritis	days
Due to	
Due to	
Other conditions: Cerebral Hemorrhage	3 days

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. F. Benson M. D. or other
Address: Port Deposit Md. Date signed: 10/29/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(93d)

10529

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Near Elk Mills
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days): 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Elkton RFD 3
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Helena Margaret Nurnberg.

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widow
8 (b) Name of husband or wife: Joseph Nurnberg
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Oct 1 - 1863

8. AGE: Years: 77 Months: Days: 3 If less than one day ____ hrs. ____ min.

9. Birthplace: Wilmington Delaware
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER
12. Name: Charles Schmith
13. Birthplace: Germany.
MOTHER
14. Maiden name: Louisa Sekterheim
15. Birthplace: Germany.
16. Informant: Mr Leo Nurnberg.
Address: Elkton R.D.3 Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 8 - 1940 (month) (day) (year)
Cemetery or crematory: Cathedral Cemetery
Location: Wilmington Del
18. Funeral director: Florence E Abernathy
Address: Elkton Md R.D. 5
19. Oct 7 1940 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 5 1940, at 5:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1940 to Oct 5 1940, and that I last saw her alive on October 5 1940.

Immediate cause of death: Myocarditis
Due to: Hypertension
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. Earle Weggenmann MD
M. D. or other
Address: Newark, Del Date signed: 10-6-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10530

CERTIFICATE OF DEATH

Reg. Dist. No. 91

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Chesapeake City
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County: Chester
City or town: Willowdale Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: J. Morris Palmer

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Elizabeth Hulbert
6(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct 10, 1940 6:30 PM
8. AGE: Years: 67 Months: 0 Days: 29 If less than one day: hrs. min.
9. Birthplace: Pa (Town, county, and state)
10. Usual occupation: Insurance
11. Industry or business:
FATHER 12. Name: Thomas Elwood Palmer
13. Birthplace: Pa
MOTHER 14. Maiden name: Hannah Shortlidge
15. Birthplace: Pa
16. Informant: Mrs Alfred H Bailey
Address: Newtown Square Pa
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 14 1940 (month) (day) (year)
Cemetery or ~~cremetory~~: West Chester Friends Cemetery
Location: West Chester, Pa
18. Funeral director: H. W. Pippin
Address: Elkton, Maryland
19. (Date rec'd by registrar) 1940 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 1940, at 6.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Not attended 19 , to 19 , and that I last saw h alive on 19 .

	DURATION
Immediate cause of death: Acute Dilatation of Heart	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE: John D. Sluis M D Coroner
M. D. or other
Address: Rising Sun Md Date signed 10/10-1940

RECEIVED
NOV 2 1940
BUREAU V. S.

10531

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(83B)

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Union Hospital

Stay in hospital or inst. (yrs., or mos., or days): 14 hrs.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Conowingo Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Jacob L. Peters

3. (b) Social Security Number

4. Sex: Male

5. Color or race: Black

6. (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): unknown.

8. AGE: Years: 54 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Conowingo Md.
(Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business

FATHER
12. Name: Levi Peters
13. Birthplace: Conowingo Md.

MOTHER
14. Maiden name: Isabelle Boody.
15. Birthplace: Conowingo Md.

16. Informant: Geo Peters.
Address: Rowlandville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 19, 1940 (month) (day) (year)

Cemetery or crematory: Mt Zoar

Location: Conowingo Md.

18. Funeral director: J E Lyson.
Address: Rising Sun Md.

19. Oct 10 1940 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9, 1940, at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 9, 1940, to Oct. 9, 1940, and that I last saw him alive on Oct. 9, 1940.

Immediate cause of death: cerebral embolism.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Elkton, Md. Date signed: 10/9/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

(T)

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

10532

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Port Deposit, Rural
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days): 88 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Port Deposit, Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Lewrenna E. Rawlings, Lewrenna E
3. (b) Social Security Number: none

4. Sex: female
5. Color or race: white
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): June 16, 1852
8. AGE: Years 88 | Months 4 | Days 4 | If less than one day hrs. min.
9. Birthplace: Port Deposit, Cecil Co., Md
(Town, county, and state)
10. Usual occupation: House work
11. Industry or business: Own Home
FATHER
12. Name: Francis Marion Rawlings
13. Birthplace: Cecil Co., Md
MOTHER
14. Maiden name: Adeline Henshaw
15. Birthplace: Rowlandville, Md.
16. Informant: Lucy Coulson
Address: Port Deposit, Md. R.F.D.
17. Hopewell cem. Burial Date thereof: Oct. 23, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Hopewell cem.
Location: Port Deposit, Md. R.F.D.
18. Funeral director: Lee A. Patterson
Address: Perryville, Md.
19. Oct. 22, 1940 Irene E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20 1940, at 11 05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept — 1920, to October 20 1940, and that I last saw h PY alive on October 20 1940.
Immediate cause of death: Chronic Myocarditis — DURATION: 20 yrs
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. J. Benson M.D.
M. D. or other
Address: Port Deposit Md Date signed: 10/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

10533

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:

County: Cecil

City or town: Outside Rising Sun Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 78 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Outside Rising Sun, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: J. Frank Reynolds

3. (b) Social Security Number: —

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Ella Reynolds.

7. Birth date of deceased (mo., day, yr.): Sept 8, 1862

6.(c) If alive, give age: 71 years

8. AGE: Years: 78 Months: 1 Days: 13 If less than one day: hrs. min.

8. Birthplace: Colora, Cecil Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER
12. Name: Samuel Reynolds
13. Birthplace: Rowlandville Md.

MOTHER
14. Maiden name: Susan McVey
15. Birthplace: Lancaster Co. Pa.

16. Informant: Ella Reynolds.
Address: Rising Sun Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Oct 25 1940 (month) (day) (year)

Cemetery or crematory: Brookview

Location: Rising Sun Md.

18. Funeral director: J. E. Tyson.
Address: Rising Sun Md.

19. 10/24 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-21 1940, at 11.10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-21 1940, to 10-21 1940 and that I last saw him alive on 10-21 1940

Immediate cause of death: Coronary Thrombosis

Due to:

Due to: Cardiac Asthma

Other conditions:
(Include pregnancy within 3 months of death)

	DURATION
Immediate cause of death	
Due to	
Due to	
Other conditions	

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Ell Dodson Mch M. D. or other

Address: Rising Sun Md. Date signed: 10-22-40

Permit issued 10-24-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. S.

Dr Morrison

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

10534

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 112 Moffit St
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: Ulyses Springer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1857

8. AGE: Years: 83 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: no information (Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER
12. Name: no ? Springer
13. Birthplace: no information

MOTHER
14. Maiden name: no information
15. Birthplace: no information

16. Informant: Mrs Ada Davis
Address: Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 24 1940 (month) (day) (year)
Cemetery or crematory: Elkton Cemetery
Location: Elkton

18. Funeral director: J. W. Pippin
Address: Elkton Md

19. Oct 24 1940 (Date rec'd by registrar) J R Bragg Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22 1940, at 2.30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 22 1940, to Oct 22 1940
and that I last saw him alive on Oct 22 1940

Immediate cause of death	DURATION
Chronic endocarditis	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. T. Morrison M.D.
M. D. or other
Address: Elkton, Md Date signed 10-24-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 5 1940
U. S. DEPT. OF AGR.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

10535

Reg. Dist. No. 96

1. PLACE OF DEATH:
County Cecil
City or town Port Deposit, Rural
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 85 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Port Deposit, R.F.D. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME James Wilson Squier

3. (b) Social Security Number none

4. Sex Male
5. Color or race white
6. (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Helen Rowland Squier
6(c) If alive, give age about 72 years
7. Birth date of deceased (mo., day, yr.) Sept 27, 1855

8. AGE: Years 85 Months — Days 12 If less than one day hrs. min.

9. Birthplace Port Deposit, Cecil co. Md.
(Town, county, and state)
10. Usual occupation Attorney at Law
11. Industry or business Private Practice
FATHER 12. Name Rev. John Squier
13. Birthplace Scotland
MOTHER 14. Maiden name Isabella Wilson
15. Birthplace Chester Co., Pa.
16. Informant C. C. Squier
Address Port Deposit, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 12, 1940 (month) (day) (year)
Cemetery or crematory West Nottingham
Location Colora, Md. R.F.D.
18. Funeral director Lee A. Patterson
Address Perryville, Md.
19. Oct. 11, 1940 Irene E. Daugherty.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1940, at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1910, to Oct. 9 1940
and that I last saw him alive on Oct. 9, 1940.

Immediate cause of death Chronic Myocarditis — DURATION 5 yrs
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. G. Jack M. D. or other
Address Port Deposit, Md. Date signed Oct 10/40

VS A15 (T) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 5 1940
BUREAU V. S.

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of informati[illegible]refully. The correct age

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

10536

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos. 10 days

Hospital, institution, or street address where death occurred:
Veterans' Administration

How long in hospital or institution? July 9, 1940 (Marine Hosp)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 132 Prospect Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: World

3.(a) FULL NAME: TILGHMAN, William H.

3.(b) Social Security Number: 219-07-9110

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	Married

6.(b) Name of husband or wife: Mrs. Milbourn Tilghman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 10, 1892

8. AGE: Years	Months	Days	If less than one day
48	5	16	..... hrs. ..... min.

9. Birthplace: Chestertown, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Coal dealer

FATHER
12. Name: Charles Tilghman
13. Birthplace: Chestertown, Md.

MOTHER
14. Maiden name: Emma Graves
15. Birthplace: Pomona, Maryland.

16. Informant: Hospital records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 26, 1940 (month) (day) (year)

Cemetery or crematory: Chestertown

Location: Chestertown, Md.

18. Funeral director: Lewis A. Henry

Address: LEWIS A. HENRY Cambridge, Md.

19. Oct. 26, 1940 (Date rec'd by registrar) Irma E. Haughey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26 1940, at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16, 1940, to Oct. 26, 1940 and that I last saw h...im alive on October 26 1940

Immediate cause of death	DURATION
Cerebral Hemorrhage	10-21-40
Due to	
Due to	
Other conditions: General Arteriosclerosis	Unknown
Hypertensive heart disease	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op. ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of .....

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury -- Injured at work?

23. SIGNATURE: C. F. Davis M.D.
C. F. DAVIS, M.D., Clinical Director
Address: Veterans' Administration Perry Point, Md. Date signed: 10-26-40

is especially important. Physicians: please write the causes of death ...ry and legibly.

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

10537

CERTIFICATE OF DEATH

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 28 days

Hospital, Institution, or street address where death occurred:
Veterans' Administration

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1523 Marshall Street,
(If rural, give LOCATION)

2.(a) If veteran, name war: World

3.(a) FULL NAME

TRUST, Herman

3.(b) Social Security Number

218-09-1394

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widower

6.(b) Name of husband or wife: Ella Mae Pearce - deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 2, 1896

8. AGE: Years	Months	Days	If less than one day
44	5	23	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Chauffeur & roof repairman

11. Industry or business

FATHER
12. Name: Herman T. Trust - deceased
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown - deceased
15. Birthplace: Unknown

16. Informant: Social Service & hospital records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: October 25, 1940 (month) (day) (year)

Cemetery or crematory: Parkwood Cemetery

Location: Baltimore, Md.

18. Funeral director: George J. Ruth, Inc.

Address: 1736-38 Harford Ave. Baltimore, Md.

19. Oct. 25 1940 (Date rec'd by registrar) Irene E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25 1940 at 7:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27, 1940, to Oct. 25 1940 and that I last saw him alive on October 25 1940

Immediate cause of death	DURATION
Uremia	1 week
Due to	
Due to	
Other conditions	
Nephrosclerosis	2-3 yrs.
Myocardial change (Include pregnancy within 3 months of death)	2-3 yrs.

Major findings of operation: ---

Date of op. ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work?

23. SIGNATURE: C. F. Davis A.E.D.

C. F. DAVIS, M.D., Clinical Director

Address: Veterans' Administration, Perry Point, Maryland. Date signed 10-25-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

CEIVED
NOV 5 1940
KEAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (175-2)

CERTIFICATE OF DEATH

10538

Reg. Dist. No. 91

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil Co. Md.
City or town: Near Chesapeake City Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil Co.
City or town: Near Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Emma May Walls

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

8.(b) Name of husband or wife: Howard F. Walls
Kent Co. Md. 8.(c) If alive, give age 61 years
7. Birth date of deceased (mo., day, yr.): Feb. 27th 1883

8. AGE:

Years	Months	Days	If less than one day
57	7	13	hrs. min.

8. Birthplace: Kent Co. Md.
(Town, county and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: Samuel Hurd
13. Birthplace: Kent Co Md

MOTHER
14. Maiden name: Martha E. Murfitt
15. Birthplace: Kent Co. Md

16. Informant: Ethel M. Pearce
Address: 217 Jessup St. Wil. Del.

17. Burrial (Burial, cremation, or removal. Which?) Date thereof Oct. 17/40 (month) (day) (year)
Cemetery or crematory: Cecilton Cemetery
Location:

18. Funeral director: John F. Applegate
Address: Cecilton, Md.

19. Received 10/16 1940 (Date rec'd by registrar) Mrs. Ralph D. Wells Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 14th 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 40 19 to Oct 14/40 19
and that I last saw h in alive on Oct 13/40 19

Immediate cause of death	DURATION
Acute Carbuncle of Left Arm	3 weeks
Due to Staph. septic. in Sinus and Abscess eyelid	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Walter L. Lemmon M. D. or other
Address: Middletown Date signed 10/14/40

RECEIVED
NOV 2 1940
U. S.